Crisis Intervention Awareness / De-Escalation (CIAD)

Assigned Course Number:

Author: **Officer Daniel Nelson #6883**

Reviewed by: **Sergeant Joseph Fountain #5586**

Date Written/Revised: **12/21/12**

Approving Authority: PENDING

Overview:
CIAD is an 18-hour course providing, skills-based training to officers on identifying behaviors associated with persons in crisis and tools to assist officers in de-escalation.

The course will consist of 5 major blocks of instruction:

1. Field evaluation of persons in crisis.
2. Tactical communication with emphasis on a practical de-escalation model.
3. Crisis intervention skills, the Graduated Intercept Continuum, and community referral resources.
4. Suicide intervention.
5. Involuntary Treatment Act Law and Mental Health Court.

Course Goal(s):
Enhance the ability of the officers to effectively identify and intervene with individuals who are exhibiting mental-health-related behaviors and symptoms.

Course Objective(s):
Upon completion of this course, participants will:

1. Identify behaviors and symptoms associated with mental health disorders.
2. Apply the De-Escalation Model while interacting with an individual in crisis.
3. Exercise discretionary options and mental health care resources using the Graduated Intercept Continuum.

4. Effectively assess risk with a suicidal person utilizing the "C.P.R." system.

5. Accurately and concisely justify emergent detention document field evaluation and request referral.

Target Audience:

All sworn Seattle Police Department employees. .

Class size:
Maximum of 12, minimum of 6.

Evaluation Process:
Instructors will evaluate performance during exercises and written tests.

Logistical Information:

Site: Seattle Police Department Support Facility (Park 90/5), 2nd Floor S.W.A.T. briefing room.

Training Equipment:

Note-taking materials

Staffing Requirements:

Lead Instructors: 1
CIT Cadre Instructors: 2

Training summary:

Students will be taught using a combination of lecture, skills training, and performance of drills and/or scenario training.

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Training schedule: Day One

-00:30	Instructors on site, prepare for training
00:00	Introductions, student sign in, organize into groups.

00:20	Field evaluation of persons in crisis – presentation
00:50	(break)
01:00	Video and discussion – "Sword Man"
01:10	Field Mental Status Exam
01:30	Video and discussion – personal narratives of persons with mental illness
01:50	(break)

02:00	De-Escalation Model – presentation
02:20	Exercise – coached practice + interactive video
02:50	(break)

03:00	De-Escalation Model + Active listening (MOREPIES) -– presentation
03:20	Exercise - D'Logo interactive video

04:00	Lunch

05:00	Suicide Intervention: CPR Model & videos - presentation
05:20	Suicide Intervention exercise (round robin "jumper")
05:50	(break)

06:00	Emergent detention (EMD) / Involuntary Treatment Act (ITA) - presentation
06:20	EMD / ITA review
06:30	Exercise – Document and discuss "jumper" EMD
06:50	(break)

07:00	Review EMD
07:05	Exercise - EMD – 2 scenario videos, document and discuss
07:50	(break)

08:00	Review W/Exercise (Practice Test)
09:00	End day one

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Training schedule: Day Two

-00:30	Instructors on site, prepare for training
00:00	Review day one material – interactive Quizdom
00:50	(break)

01:00	PTSD Video and discussion – "Now, Then"
01:30	Community mental health resources - presentation
01:50	(break)

02:00	Graduated Intercept Continuum– presentation
02:20	Exercise – interactive Quizdom
02:50	(break)

03:00	Comprehensive review – material and skills

04:00	Lunch

05:00	Evaluation – Written test and scenarios Two groups, three scenarios.
06:30	Rotate
08:00	Test scoring and discussion

08:30	Wrap and class evaluation
09:00	End training

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Performance/Learning Objectives:

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Interest Introduction:

Video of crisis call with variables for response.

Material Introduction:

This training was developed to give officers additional tools for dealing with individuals who are emotionally distressed or are currently suffering from symptoms of mental illness.

In 2012 over 5,000 cases were sent to the Crisis Intervention Unit for additional follow up. This number shows that the frequency at which officers are interacting with individual who are either emotionally distressed or suffering from some sort of mental illness is happening at a much greater frequency.

Additionally, the number of members returning from various overseas deployments for wartime operations is also increasing. Statistics show that multiple deployments to wartime operations dramatically increase the likelihood of members of the armed forces suffering from symptom of Post-Traumatic Stress Disorder (PTSD).

This material was gathered after intensive research as well as field-tested techniques. This curriculum was complied after consulting with partners in mental health field.

- Nobody chooses to develop a mental illness. One in four families is affected.
- Mental illness is a biological illness just like heart disease, cancer of diabetes.

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- There is no cure, but many people reach recovery and live full, productive lives.
- Many medication of r mental illness create very negative side effects, including kidney and liver disease, diabetes, tardive dyskinesia (involuntary movements of the tongue, lips, face, trunk, and extremities) (Brasic) and death. These factors make medication compliance very difficult. Suggestions like, "Just take your meds" are viewed as insensitive to how difficult this is.
- People with mental illness experience a high level of stigma and social isolation, which inhibits seeking treatment.
- Most people, even in the middle of a mental health crisis, respond positively to kind and patient behavior.

Field evaluation of persons in crisis:

Objective*:* Identify common observable signs and symptoms of a person suffering from mental illness.

What specific OBJECTIVE evidence is present to assist in reaching a conclusion that a person is in crisis or suffering from a mental illness?

Diagnosis is defined as a cluster of symptoms.

Schizophrenia - Symptoms of schizophrenia typically begin between adolescence and early adulthood for males and a few years later for females, and usually as a result of a stressful period (such as beginning college or starting a first full time job). Initial symptoms may include delusions and hallucinations, disorganized behavior and/or speech. As the disorder progresses symptoms such as flattening or inappropriate affect may develop.

- Odd behavior
- Poor eye contact, flat affect
- Disorganized speech, non-sensical statements
- The individual appears to be responding to internal stimuli
- The individual makes odd statement of has a fixed unrealistic belief in something
- Paranoia, persecutory statements

Bi-polar Disorder - Bipolar I: For a diagnosis of Bipolar I disorder, a person must have at least one manic episode. Mania is sometimes referred to as the other extreme to depression. Mania is an intense high where the person feels euphoric,

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almost indestructible in areas such as personal finances, business dealings, or relationships. Mania is also experienced as a terrifying loss of control, because of the extended sleeplessness and also due to some individuals experiencing psychosis. Individuals may have an elevated self-esteem, be more talkative than usual, have flight of ideas, a reduced need for sleep, and be easily distracted. The high, although it may sound appealing, will often lead to severe difficulties in these areas, such as spending much more money than intended, making extremely rash business and personal decisions, involvement in dangerous sexual behavior, and/or the use of drugs or alcohol. Depression is often experienced as the high quickly fades and as the consequences of their activities becomes apparent, the depressive episode can be exacerbated.

Bipolar II: Similar to Bipolar I Disorder, there are periods of highs as described above and often followed by periods of depression. Bipolar II Disorder, however is different in that the highs are hypo manic, rather than manic. In other words, they have similar symptoms but they are not severe enough to cause marked impairment in social or occupational functioning and typically do not require hospitalization in order to assure the safety of the person.

Depression - Symptoms of depression include the following:

- depressed mood (such as feelings of sadness or emptiness)
- reduced interest in activities that used to be enjoyed, sleep disturbances (either not being able to sleep well or sleeping to much)
- loss of energy or a significant reduction in energy level
- difficulty concentrating, holding a conversation, paying attention, or making decisions that used to be made fairly easily
- Suicidal thoughts or intentions.

PTSD - Post-traumatic Stress Disorder (PTSD)

Symptoms include re-experiencing the trauma through nightmares, obsessive thoughts, and flashbacks (feeling as if you are actually in the traumatic situation again). There is an avoidance component as well, where the individual avoids situations, people, and/or objects which remind him or her about the traumatic event (e.g., a person experiencing PTSD after a serious car accident might avoid driving or being a passenger in a car). Finally, there is increased anxiety in general, possibly with a heightened startle response (e.g., very jumpy, startle easy by noises).

- Symptoms include re-experiencing the trauma through:
- Disturbing dreams or nightmares, distressing and intrusive memories
- Flashbacks (sensory re-experiencing of trauma)
- Dissociation
- Panic / Distress / physiological reaction upon exposure to trauma triggers
- Difficulty sleeping
- Anger, difficulty concentrating, hyper-vigilant, paranoid, avoidance / emotional numbing
- Exaggerated startle response
- Diminished interest in activities, isolating, alienating from others, flat affect, depression
- Sense of foreshortened future
- Substance abuse

Acute Stress Disorder –

Symptoms include dissociative symptoms such as numbing, detachment, a reduction in awareness of the surroundings, de-realization, or depersonalization;

re-experiencing of the trauma, avoidance of associated stimuli, and significant anxiety, including irritability, poor concentration, difficulty sleeping, and restlessness. The symptoms must be present for a minimum of two days and a maximum of four weeks and must occur within four weeks of the traumatic event for a diagnosis to be made.

-numbing

-detachment

-a reduction in awareness of the surroundings, de-realization, or depersonalization

-re-experiencing of the trauma

-avoidance of associated stimuli

-significant anxiety

-including irritability

-poor concentration

-difficulty sleeping and restlessness.

Borderline Personality Disorder –

The major symptoms of this disorder revolve around unstable relationships, poor or negative sense of self, inconsistent moods, and significant impulsivity. There is an intense fear of abandonment with this disorder that interferes with many aspects if the individual's life. This fear often acts as a self-fulfilling prophecy as they cling to others, are very needy, feel helpless, and become overly involved and immediately attached. When the fear of abandonment becomes overwhelming, they will often push others out of their life as if trying to avoid getting rejected. The cycle most often continues as the individual will then try everything to get people back in his or her life and once again becomes clingy, needy, and helpless.

The fact that people often do leave someone who exhibits this behavior only proves to support their distorted belief that they are insignificant, worthless, and unloved. *At this point in the cycle, the individual may exhibit self-harming behaviors such as suicide attempts, mock suicidal attempts (where the goal is to get rescued and lure others back into the individual's life), cutting or other self-mutilating behavior.* There is often intense and sudden anger involved, directed both at self and others, as well a difficulty controlling destructive behaviors

- Cutting, scratching, or pinching skin enough to cause bleeding or a mark that remains on the skin
- Banging or punching objects to the point of bleeding
- Ripping and tearing skin
- Carving words or patterns into skin
- Burning self with cigarettes, matches, hot water
- Pulling out hair
- Overdosing on medication but it was NOT meant as a suicide attempt
- Attention seeking behavior
- Dramatic behaviors
- Individual seems to be overly involved in others

Psychotic Disorders – Experiencing pervasive and detailed hallucinations (hearing, smelling, and seeing) and fixed delusions ("People are conducting experiments with my cerebral spinal fluid"). (All Psych Online)

Three (3) main types of causes

Biologically Induced- The exact cause of psychotic disorders is not known, but researchers believe that many factors may play a role. Some psychotic disorders tend to run in families, suggesting that the tendency, or likelihood, to develop the

disorder may be inherited. Environmental factors may also play a role in their development, including stress, drug abuse and major life changes.

Medically Induced- Hallucinations, delusions, or other symptoms may be the result of another illness that affects brain function, such as a head injury or brain tumor.

Substance Induced- This condition is caused by the use of or withdrawal from some substances, such as alcohol and crack cocaine, that may cause hallucinations, delusions, or confused speech. (Medicine Net)

EXERCISE – Video – Sword Man (VideoSource)

- 10.5 hour standoff
- "Thanks for not killing me. I thought you were all demons."
- No illicit drugs or alcohol found in blood during treatment at hospital.

EXERCISE – Personal narratives of persons with mental illness.

Mental Status Exam -

Level of Consciousness

The level of consciousness refers to the state of wakefulness of the patient and depends both on brainstem and cortical components. Levels are operationally defined by the strength of stimuli needed to elicit responses.

A *normal* level of consciousness is one in which the patient is able to respond to stimuli at the same lower-level of strength as most people who are functioning without neurologic abnormality.

Clouded consciousness is a state of reduced awareness whose main deficit is one of inattention. Stimuli may be perceived at a conscious level but are easily ignored or misinterpreted.

Delirium is an acute or sub acute (hours to days) onset of a grossly abnormal mental state often exhibiting fluctuating consciousness, disorientation, heightened irritability, and hallucinations. It is often associated with toxic, infectious, or metabolic disorders of the central nervous system.

Obtundation refers to moderate reduction in the patient's level of awareness such that stimuli of mild to moderate intensity fail to arouse; when arousal does occur, the patient is slow to respond.

Stupor may be defined as unresponsiveness to all but the most vigorous of stimuli. The patient quickly drifts back into a deep sleep-like state on cessation of the stimulation.

Coma is unarousable unresponsiveness. The most vigorous of noxious stimuli may or may not elicit reflex motor responses.

When examining patients with reduced levels of consciousness, noting the type of stimulus needed to arouse the patient and the degree to which the patient can respond when aroused is a useful way of recording this information.

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Appearance and General Behavior

These variables give the examiner an overall impression of the patient. The patient's physical appearance (apparent vs. stated age), grooming (immaculate/unkempt), dress (subdued/riotous), posture (erect/kyphotic), and eye contact (direct/furtive) are all pertinent observations.

Speech and Motor Activity

Listening to spontaneous speech as the patient relates answers to open-ended questions yields much useful information. One might discern problems in output or articulation such as Parkinson's disease, the halting speech of the patient with word-finding difficulties, or the rapid and pressured speech of the manic or amphetamine-intoxicated patient. Overall motor activity should also be noted, including any tics or unusual mannerisms. Slowness and loss of spontaneity in movement may characterize dementia or depression.

Affect and Mood

Affect is the patient's immediate expression of emotion; *mood* refers to the more sustained emotional makeup of the patient's personality. Patients display a range of affect that may be described as broad, restricted, labile, or flat. Affect is inappropriate when there is no consonance between what the patient is experiencing or describing and the emotion he is showing at the same time (e.g., laughing when relating the recent death of a loved one).

Affect must be judged in the context of the setting and those observations that have gone before.

Thought and Perception

The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns, or are these

concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?

The more seriously ill patient may exhibit overtly *delusional thinking* (a fixed, false belief not held by his cultural peers and persisting in the face of objective contradictory evidence), *hallucinations* (false sensory perceptions without real stimuli), or *illusions* (misperceptions of real stimuli). Because patients often conceal these experiences, it is well to ask leading questions, such as, "Have you ever seen or heard things that other people could not see or hear? Have you ever seen or heard things that later turned out not to be there?" Likewise, it is necessary to interpret affirmative responses conservatively, as mistakenly hearing one's name being called, or experiencing hallucinations in the peri-sleep period, is within the realm of normal experience.

Attitude and Insight

The patient's attitude is the emotional tone displayed toward the examiner, other individuals, or his illness. It may convey a sense of hostility, anger, helplessness, pessimism, over dramatization, self-centeredness, or passivity. Likewise, the patient's attitude toward the illness is an important variable. Is the patient a help-rejecting complainer? Does the patient view the illness as psychiatric or non-psychiatric? Does the patient look for improvement or is he or she resigned to suffer in silence?

Patient attitude often changes through the course of the interview, and it is important to note any such changes. (Martin, 1990)

EXERCISE – Video and Quizdom Mental Health Status Exam.

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De-Escalation

De-escalation is the use of words and actions to reduce a heightened emotional and physical state, in order to facilitate calm, rational interaction.
Police should use de-escalation as a tactical communication tool when they recognize a person's state of behavioral escalation prevents effective communication and objective problem-solving. Officers should attempt de-escalation only when it is safe to do so. De-escalation is a component of police response options, and like other response options, it is appropriate and effective in specific situations.

Always ensure you, other officers, bystanders and the subject are safe from immediate harm before attempting de-escalation. De-escalation is <u>not</u> a reasonable alternative to <u>necessary</u> force.

Jail is about the least helpful place for someone in a mental health crisis to get stabilized. Many people with mental illness have been jailed, were victimized at that time and are very afraid of police and the jail system as a result. This absolutely influences behavior around police officers. (Lindquist, 2013)

Recognizing Escalation: The perception of fear, triggers automatic responses. The perception can be fear of physical danger, embarrassment, negative consequences, abandonment, "loss of face" or other major or seemingly minor consequences. The automatic response is described as *psychophysical arousal*, meaning that our brains, emotions and bodies began working at heightened levels of performance.
When a situation is perceived as dangerous or having major negative consequences, a part of our brains called the *amygdale* initiates a response by

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stimulating brain chemicals that increase performance for survival. Observable effects of fear-induced psychophysical arousal:

- Increased muscle tension, especially in neck and shoulders.
- Increased breathing rate; shallower breaths.
- Rapid eye movements; eyes are opened wide and have a flattened appearance.
- Perspiration; skin flushed, especially in the face.
- Tremors (shaking); loss of fine-motor skills.
- Rapid, pressured speech; yelling or frequently interrupting.
- Teeth clenched, jaw set.
- Dry mouth, repeatedly licking lips.
- Irrational, expansive or nonsensical statements or physical actions.
- Failure to follow simple, reasonable requests or instructions.

As with any evaluation of behavior, we look for the totality of factors to judge whether the person is in a significantly escalated state. Psychophysical arousal promotes rapid, intuitive reaction to potential risks – deliberate, logical thought is disfavored. We know from brain scans that when experiencing fear, brain activity in the areas of the brain responsible for objective reasoning significantly decreases.

A fear response makes constructive communication and problem-solving very difficult, if not impossible. Once an officer recognizes a person is experiencing a fear response, he or she should consider de-escalation before attempting problem-solving.

De-escalation Method:

Through skillful use of words and actions, we can reduce the fear response and its effects and encourage voluntary compliance and problem-solving. The method below provides a road map for de-escalation.

SAFE – Ensure that no one is imminent danger before attempting de-escalation.

"Is the scene safe? The scene is safe."

PRESENCE – We can best minimize fear when we present a strong, protective presence. Establish a calm, poised and assertive presence.

"I am calm, poised and assertive."

ENGAGE – Establish communication. We know when we've established communication when the person makes eye contact.

"Sir, sir, I'm over here."

CONTEXT – Define a general, positive goal and establish ground rules.

"I can listen to you when you stop yelling."

REFLECT – Active listening techniques support rational thought and reduce fear

"Uh-huh…Umm...So you're really angry at John, is that right?"

Active listening techniques: MOREPIES

GUIDE – Verify that de-escalation has occurred to the point that problem-solving is possible.

"Can we work on that together and try to get you some help?"

The script allows for automatic use of these techniques under stress or in challenging situations. When the script is mastered, officers will find it easy to

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alter phrases to fit the needs of the situation. Keeping the steps in mind supports a consistent strategy.

EXERCISE – Stand up and verbally practice the De-escalation framework and model.

Active Listening (MOREPIES) – Used during "reflect" stage of de-escalation.

M - Minimal Encouragers - Small verbal statement to acknowledge that you are hearing what they the individual is saying and you are ready for the next piece of information.

"Uh-huh, Yeah, Sure"

O – Open-Ended Questions - Asking open ended questions which require more that a one or two word response forces the individual to elaborate in their answers forcing them to access their cognitive (forebrain) thought process.

"What brought us here today? How did that make you feel? Then what happened?"

R – Reflecting / Mirroring - A quick re-cap of what the individual had just said to show that you were listening to what he / she is communicating.

"I lost my job and I don't feel like living anymore. You lost your job and you don't feel like living anymore."

E – Emotional Labeling - Labeling the emotions that the individual is expressing with non-verbal cues or what he / she are verbally communicating.

"I have been working at the plant for 10 years and then they just up and fire me!?"

"You're angry that they fired you."

P – Paraphrasing - Like reflecting / mirroring but a condensed version of what is being communicated. This is best used at the end of a long monologue.

"I lost my job, my partner left me, I am out of money and I don't feel like living anymore."

" What I hear you saying is that you lost your job, partner, money and you don't feel like living anymore."

I – Use of "I" Statements - Use of "I" Statements can be an excellent way to establish boundaries when dealing with someone in crisis.

"I can listento you when you stop yelling."

"I can talk to you when you put down the stick."

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"I am trying to understand you but it is difficult when you won't communicate with me."

E - Effective Pauses - Effective pauses can be used as a tool to enforce boundaries that have been established, or to prompt an individual in crisis to start talking. Natural speech patterns in a conversation have "back and forth" which require input from all parties. When one of the parties stops communicating it places pressure on the other party to continue talking to ease the tension.

S – Summary - This is used as a way to re-communicate the situation, as he / she had explained it, to show that you are listening to what they have to say.

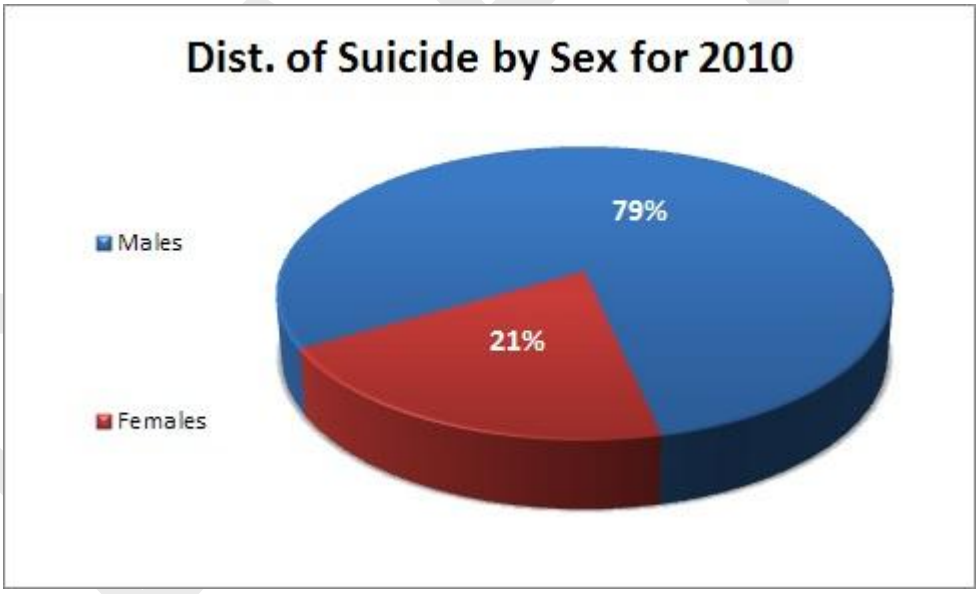
Reflecting / Mirroring + Paraphrasing

EXERCISE – Active Listening Skills (ALS) training video with embedded exercise. (FBI, 2006)

Suicide Risk and Lethality Assessment

Statistics

- Every 13.7 minutes someone in the United States dies by suicide.
- Nearly 1,000,000 people make a suicide attempt every year.
- 90% of people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death.
- Most people with mental illness do not die by suicide.
- Recent data puts yearly medical costs for suicide at nearly $100 million (2005).
- Men are nearly 4 times more likely to die by suicide than women. Women attempt suicide 3 times as often as men.
- Suicide rates are highest for people between the ages of 40 and 59. (American Foundation for Suicide Prevention)



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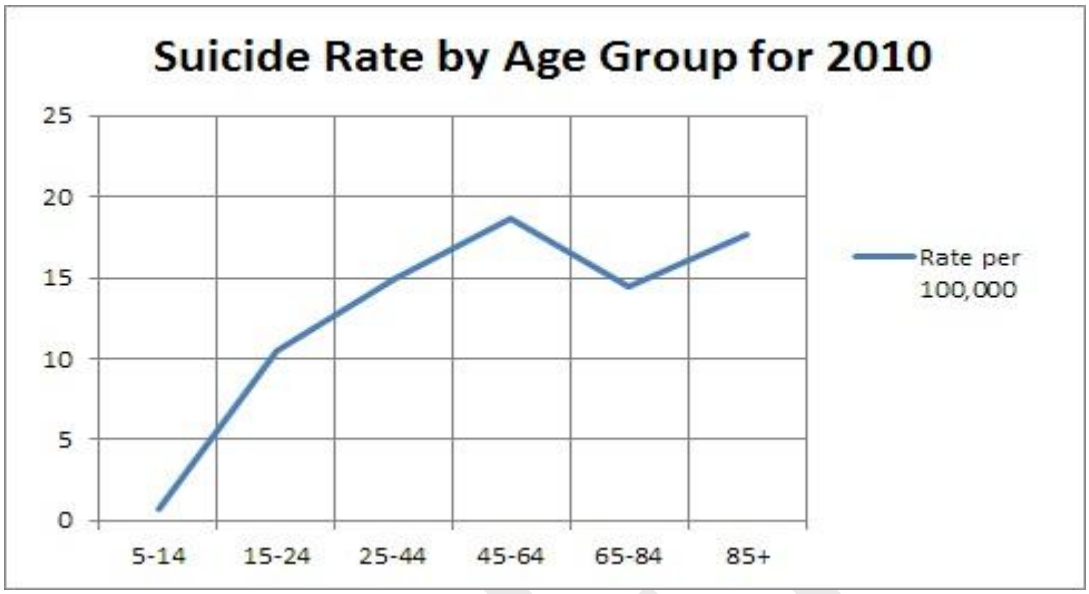

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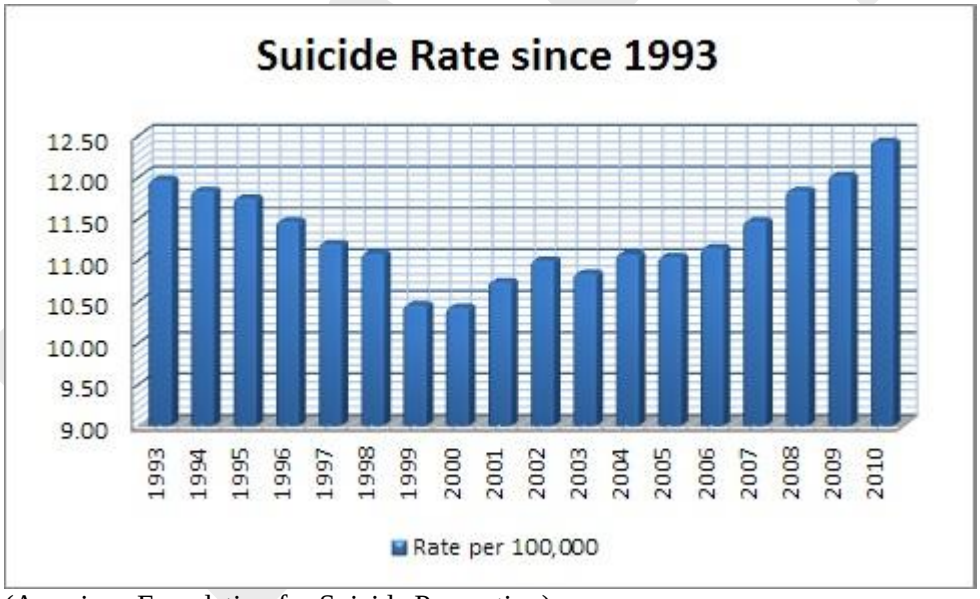

(American Foundation for Suicide Prevention)

There are four male suicides for every female suicide, but three times as many females as males attempt suicide.

- There are an estimated 8-25 attempted suicides for every suicide death. (American Foundation for Suicide Prevention)
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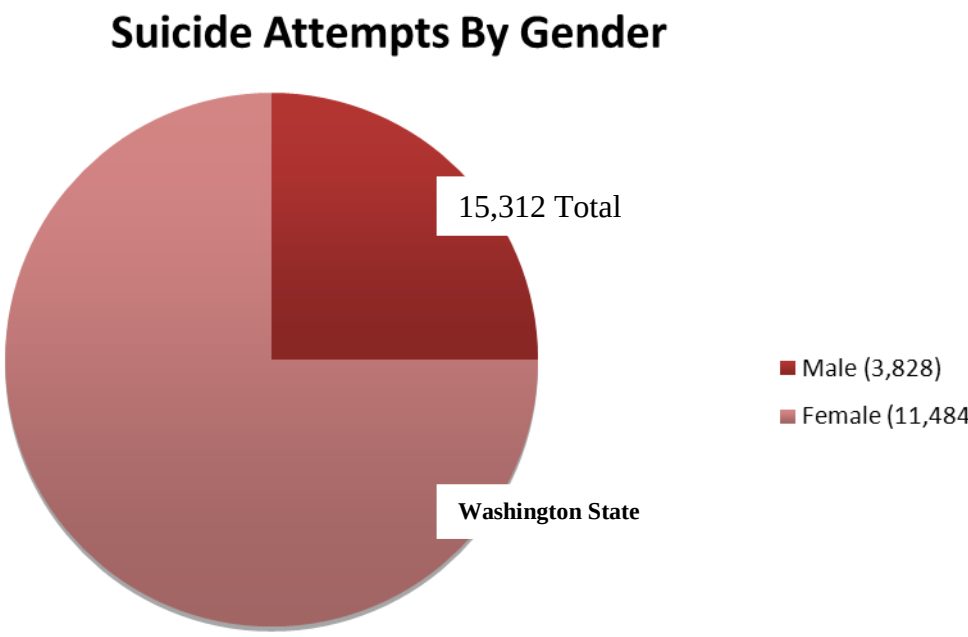
2010

State	Number of Suicides	Population	Rate	Rank
Washington	957	6,724,540	14.2	23

(American Foundation for Suicide Prevention)



Intervention Model

Ask the question:

"Are you thinking about killing yourself?"

If the answer is YES, assess the level of risk using CPR

C= Current Plan

"Do you have a plan in mind for how you will kill yourself?"

"Do you have access to the _____ (gun, knife, rope, pills, car, etc.)?"

"When do you plan to do this?"

P= Previous Behavior

"Have you ever tried to kill yourself before?"

"How did you try before?"

"What happened after your attempt?"

"Do you know anyone who has completed suicide?"

R= Resources

"Do you have a counselor, case manager, or therapist?"

"Who is generally helpful when you are having a difficult time?"

"Who can come and be with you right now?"

"What have you done in the past when you have felt like this or had these thoughts?"

EXERCISE – Suicide intervention round robin "jumper"

Emergent Detention (EMD) / Involuntary Treatment Act

Detention of mentally disordered persons for evaluation and treatment — Procedure. (ITA)

(4) A peace officer may, without prior notice of the proceedings provided for in subsection (1) of this section, take or cause such person to be taken into custody and immediately delivered to an evaluation and treatment facility or the emergency department of a local hospital: **(a)** Only pursuant to subsections (1)(d) and (2) of this section; or **(b)** When he or she has reasonable cause to believe that such a person is suffering from a mental disorder and presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled. (RCW 71.05.150)

Discuss elements:

- Reasonable cause.
- Suffering from mental disorder.
- Imminent.
- Likelihood of serious harm.
- Grave disability.

Detention and commitment process

1. Officers detain and deliver to nearest ER.
2. Hospital Social Workers
    - Evaluate
    - Stabilize
    - Refer (DMHP), resources and linkage to services
    - If drunk or high individual must first sober up before M.H. Exam.
3. DMHPs

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- More in depth evaluation of behavior specifically adhering to ITA criteria.
- Can order 72 (business)-hour to prepare for ITA Court hearing
- Patients over 13 years of age

4. King County Crisis and Commitment Court
    - 14 days, 90 days, 90 days, 180 days (repeat), up to 10 years
    - Testimony needed on some cases.
    - ITA Court vs. Mental Health Court

SPD Mental Health Contact Report

- Document observed objective behaviors
- Direct quotes from individual and/or witnesses
- Include witness contact info for testimony at K.C.C.C.C.
- Do not need to include medications (if not part of overdose evidence) or specific diagnosis
- Complete narrative on Mental Health Contact Report (affidavit level)
- Fax copy to DMHP's
-

Exercise – Videos of EMD client; Complete SPD Statement on observed behaviors (2)

Community Mental Health Resources

Seattle Municipal Mental Health Court Tracking

The Seattle Municipal Mental Health Court (SMMHC) only takes cases which occur in the City where mental illness is a primary motivating factor in misdemeanor and gross misdemeanor cases. The SMMHC is a collaborative court which engages the subject in court-supervised treatment and probation monitoring.

[Referral process]

CSC/CDF -Eligible Crime and Voluntary

The Crisis Solution Center and Crisis Diversion Facility (CSC / CDF) is a program where individuals whose behavior does not rise to the level of a mandatory mental health evaluation, can receive emergency mental health care. The diversion facility portion of the program focuses on having individuals arrested for non-violent misdemeanor and gross misdemeanor crimes, who meet the criteria, admitted in lieu of booking at King County Jail (KCJ). The purpose of the CDF is to allow quicker access to services for individuals with mental health concerns. Both the CSC and CDF are completely voluntary programs.

[Referral process]

ITA (One of the criteria is met and articulated in MHCR)

If one or more of the 4 emergent detention criteria outlined in RCW 71.05.150 (imminent danger to self, other, property or gravely disabled) are present, the individual should be sent to the closest available hospital emergency room for a mental health evaluation. The narrative portion of the Seattle Police Department

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Mental Health Contact form should be based on the specific *behaviors* that the officer witnessed while interacting with the individual. Merely having a mental health diagnosis *does not* qualify an individual for an emergent detention.

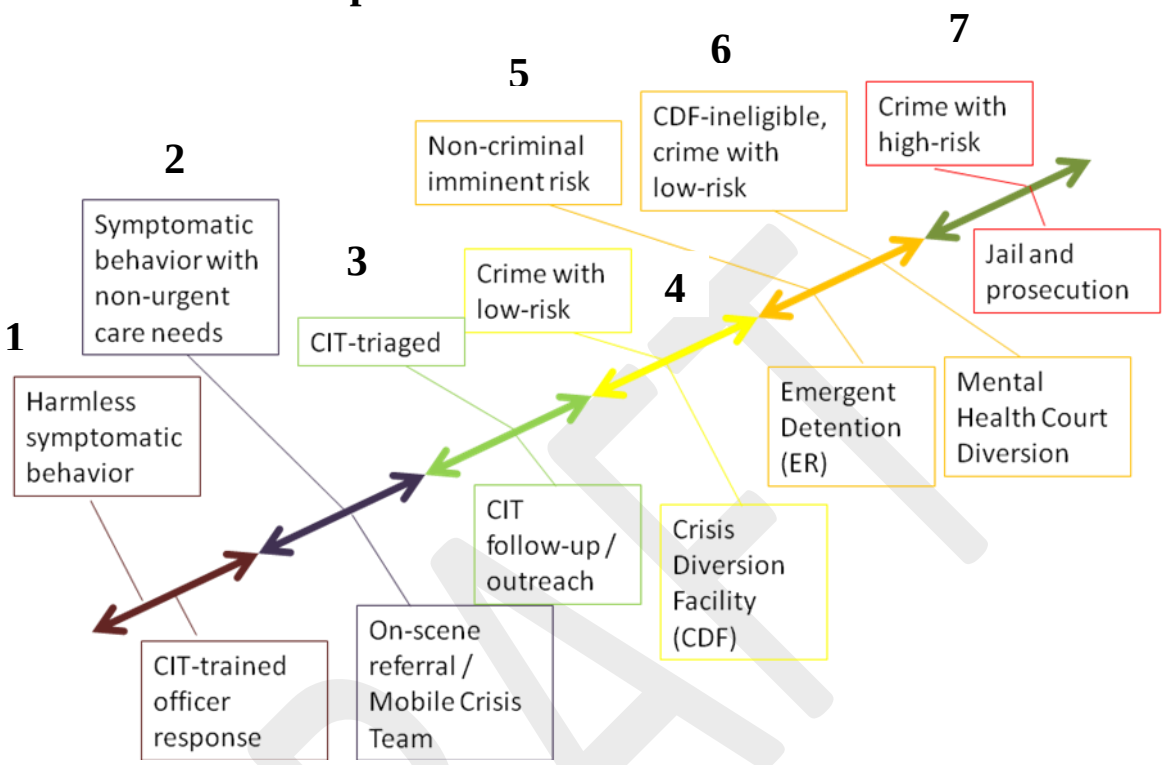
MCT

The mobile crisis team (MCT) is one of the programs available as part of the CSC / CDF. The MCT is a team of 2 Mental Health Professionals (MHP's) who area available to respond directly to the field at the request of officers at an incident. The MCT is requested through the zone dispatcher. The MCT is available 24/7.

Crisis Clinic

The crisis clinic is a telephonic resource to officers in the field. When interacting with an individual who may be in crisis or suffering from a mental health related issue, the crisis clinic can offer suggestions or possibly provide pertinent information about the individual (if he/she is working with a county funded mental health organization). A supervisor can relay if the individual is working with a case manager and provide the case managers contact information.

Graduated Intercept Continuum



Evaluation of incident specific details

- Suicide Threat
- Community Safety
- Criminal Law Violation
- Escalating Behavior

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De-Escalation Model / Script Drill

Skill Training Template (Tell, Show, Do):

Introduction (intended for new or remediation of skills):

Students stand up and begin repeating the De-Escalation script verbally, sequentially.

Explain that in a stressful situation individuals resort to their prior experiences and training. Successful, perfect, practice of the script will ensure officers perform the process during a crisis event.

Tell:

Identify discrete skill steps to perform skill verbally while physically showing skill

Set up drill by explaining we will be conducting verbal repetition of the De-Escalation model.

Show:

Demonstration of skill without descriptions or very brief key words only:

Instructor reads through script:

-Safe ["Is the scene safe? The scene is safe."]
-Presence ["I am calm, poised and assertive."]
-Engage ["Sir, sir, I am over here."]
-Context ["I can listen to you when you stop yelling."]
-Reflect ["Uh-huh…Umm…So you're really angry at John, is that right?"]
-Guide ["Can we work on that together and try to get you some help?"]

Do or Student Performance:

Student performance of script 5 times on each point:

1. Part
   -Safe ["Is the scene safe? The scene is safe."] x 5
   -Presence ["I am calm, poised and assertive."] x 5
   -Engage ["Sir, sir, I am over here."] x 5
   -Context ["I can listen to you when you stop yelling."] x 5
   -Reflect ["Uh-huh…Umm…So you're really angry at John, is that right?"] x 5
   -Guide ["Can we work on that together and try to get you some help?"] x 5

2. Whole
   -Safe ["Is the scene safe? The scene is safe."]

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-Presence ["I am calm, poised and assertive."]
-Engage ["Sir, sir, I am over here."]
-Context ["I can listen to you when you stop yelling."]
-Reflect ["Uh-huh…Umm…So you're really angry at John, is that right?"]
-Guide ["Can we work on that together and try to get you some help?"]

Coaching of Student Performance:

Coaching or correcting of student performance:

1. Positive orientation
2. Fix one thing at a time
3. Clear, concise and brief

Scenario Training Template (Do):

De-Escalation Scenario

Introduction (intended for learned skills):

Respond and de-escalate an individual in crisis utilizing the de-escalation model and active interviewing (M.O.R.E.P.I.E.S.).

Skills Required:

-De-escalation model
-Active Interviewing

Dispatch Instructions – Read to students:

Officers are needed to respond for a male adult who appears to be high or intoxicated yelling while walking around in the park.

Role Player Instructions – **DO NOT READ TO STUDENTS**:
Back Story-
Role player was just laid off from employer of 20 years. Role player was planning on retiring in 7 years. When the Role player told their domestic partner, the domestic partner began yelling at the Role player. Role player was angry and drove to the park.

Behaviors displayed:
Angry
Sad
Physically expressive.

Role player initially does not even recognize officers are on scene.
Role player will begin communicating with officers when they start De-escalation model.

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Role player will openly discuss issue with officers when they use MOREPIES, during reflecting stage.

No crimes committed during incident.
Not aggressive toward officers.
Physically compliant, but verbally escalated during incident.

Do or Student Performance:

Student performance of skills with feedback:

1. Perform the de-escalation model utilizing MOREPIES during the "Reflect" portion of the script.
2. Make appropriate referral decision (CIT/MCT).
3. Use of training pause to reset scenario as appropriate.

Coaching of Student Performance:

Coaching or correcting of student performance as above and the use of reflective reinforcement to facilitate student learning.

Scenario Training Template (Do):

Borderline Personality Disorder Scenario

Introduction (intended for learned skills):

Respond, de-escalate, and make a suicide assessment on an individual in crisis utilizing the De-escalation and C.P.R. models while conducting an active interview (MOREPIES)

Skills Required:

-De-escalation model
-Active Interviewing
-C.P.R. Assessment

Dispatch Instructions – Read to students:

Two officers are responding to an individual who called 911 because he/she is feeling suicidal.

Role Player Instructions – **DO NOT READ TO STUDENTS**:

Back Story-

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Role player has a history of suicidal ideation but has not attempted to carry out plan.
Role player is not physically injured nor have they ingested any pharmaceuticals.
Role players current ideation is that of hanging him/herself.

Behaviors displayed:
Happy to see 1st responders
Angry
Physically expressive
Non-congruent affect

Role player confirms that they are the one that called 911. Role player requests SFD to evaluate him/her for any possible physical injury. While waiting for SFD Role player will begin to "Show and tell" different objects from around his/her residence with great pride. After SFD exam, Role player will demand to go to hospital for mental health evaluation and states that he/she wants to see an MHP.
If any of the requests are denied Role player verbally escalates.
Role player will de-escalate and become agreeable when the officer utilizes the de-escalation model and suggests the CSC as a resolution to the call.

No crimes committed during incident.
Not aggressive toward officers.
Physically compliant, but verbally escalated during incident.

Do or Student Performance:

Student performance of skills with feedback:

1. Perform the de-escalation model utilizing MOREPIES.
2. Conduct a suicide assessment using the C.P.R. model.
3. Make appropriate referral decision (MCT/CSC).
4. Use of training pause to reset scenario as appropriate.

Coaching of Student Performance:

Coaching or correcting of student performance as above and the use of reflective reinforcement to facilitate student learning.

Scenario Training Template (Do):

Emergent Detention Scenario

Introduction (intended for learned skills):

Respond, de-escalate, and evaluate an individual in crisis utilizing the De-escalation and C.P.R. models while conducting an active interview (M.O.R.E.P.I.E.S.).

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Skills Required:
-De-escalation model
-Active Interviewing
-C.P.R. Assessment

Dispatch Instructions – Read to students:
Two officers are responding to an individual who is acting strangely and occasionally wandering into traffic.

Role Player Instructions – **DO NOT READ TO STUDENTS**:
Back Story-
Role player has a history of disorganized schizophrenia.
Role player is not physically injured nor have they ingested any pharmaceuticals.
Role player is unaware of his/her surroundings to the level of walking into traffic.
Role player is responding to internal stimuli.

Behaviors displayed:
Angry
Physically expressive
Unaware of surroundings
Responding to internal stimuli

Role player is talking and yelling in response to internal stimuli upon arrival of officers.
Role player will not acknowledge officers until the "Context" stage of the de-escalation model.
While interacting with officers Role player will believe that he/she is in 1922 in Chicago, IL.
While speaking with officers Role player will continually walk into traffic while responding to internal stimuli.

Criminal Violations:
Mental health related pedestrian interference

<u>Do or Student Performance:</u>

Student performance of skills with feedback:

1. Perform the de-escalation model utilizing MOREPIES.
2. Conduct a suicide assessment using the C.P.R. model.
3. Make appropriate referral decision (EmD).
4. Use of training pause to reset scenario as appropriate.

<u>Coaching of Student Performance:</u>

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Coaching or correcting of student performance as above and the use of reflective reinforcement to facilitate student learning.

Scenario Training Template (Do):

Post-Traumatic Stress Disorder Scenario

Introduction (intended for learned skills):

Respond, de-escalate, and evaluate an individual in crisis utilizing the De-escalation model.

Skills Required:
-De-escalation model
-Active Interviewing

Dispatch Instructions – Read to students:
Two officers are responding to an individual who is refusing to leave an alcove adjacent to the front entrance of a local coffee shop. The alcove is also property of the complainant.

Role Player Instructions – **DO NOT READ TO STUDENTS**:
Back Story-
Role player has undiagnosed PTSD.
Role player is not physically injured, but appears to be slightly intoxicated.
Role player is non-aggressive but appears startled every time the coffee shop door closes loudly.
No community supports in the area.

Behaviors displayed:
Angry
Physically expressive
Slight intoxication
Heightened startle reflex

Role player is lying down upon the arrival of officers.
Role player will acknowledge officers and disclose that he served in the U.S. Army.
Role player complains of persistent nightmares and startles easily by loud noises.
While describing the nightmares the Role player will verbally escalate and appear restless.
Role player will de-escalate during the "Context" portion of the de-escalation model.
Role player refuses to leave when asked by police.

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Criminal Violations:
Mental health related criminal trespass
No prior criminal history

Do or Student Performance:

Student performance of skills with feedback:

1. Perform the de-escalation model utilizing MOREPIES.
2. Make appropriate referral decision (MCT/CDF).
3. Use of training pause to reset scenario as appropriate.

Coaching of Student Performance:

Coaching or correcting of student performance as above and the use of reflective reinforcement to facilitate student learning.

Concepts Training Template (Tell, Illustrate, Do):

Explanation of Concepts:

Clear and concise explanation of concepts with illustrations to demonstrate the concepts in action.

Illustration of Concepts:

Instructor illustrates application of concepts using scenarios/videos as necessary

Do or Student Performance:

Student performance of concepts in conceptual exercises:

Coaching of Student Performance:

Coaching or correcting of student performance using of reflective reinforcement to facilitate student learning.

Review:

1. Review of Performance Objectives of Class

a. Practical application of the De-Escalation model while interacting with an individual in crisis.

b. Identification of behaviors and symptoms associated with mental health related concerns.

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c. Accurately and concisely document observed behaviors on a "SPD Mental Health Contact Report".

d. Effectively asses risk with a suicidal person utilizing the "C.P.R." system.

2. Review of class in high points that achieved the performance objectives

- Interactive Power-Point Presentation
- Interactive Video Presentation
- Scenario Based Training

3. Officer contact information for student follow-up

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Debrief:

Works Cited

All Psych Online. (n.d.). *All Psych Online*. Retrieved November 29, 2012, from www.allpsych.com: http://allpsych.com/disorders/psychotic/index.html

Amercian Foundation for Suicide Prevention. (n.d.). *American Foundation for Suicide Prevention*. Retrieved November 29, 2012, from www.afsp.org: http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_ID=04EB7CD1-9EED-9712-89C9540AFCB44481

Andrus, G. (2012, December). MHP. (D. Nelson, Interviewer)

Brasic, J. R. (n.d.). *Medscape*. Retrieved 01 14, 2013, from www.medscape.coim: http://emedicine.medscape.com/article/1151826-overview

Burnison, M. (2012, 12). MHP. (D. Nelson, Interviewer)

Crisis Clinic Seattle, W. (2012, 12 11). Suicide Risk and Lethality Assessment. *Suicide Risk and Lethality Assessment* . Seattle, wa, USA: Crisis Clinic Seattle, WA.

FBI. (2006). *D'Logo.* WILL Interactive, Inc.

Lindquist, C. (2013, 01 14). MHP (NAMI). (D. Nelson, Interviewer)

Martin, D. C. (1990). *Clinical Methods, Chapter 207.* Boston: Butterworths.

Medicine Net. (n.d.). *Medicine Net* . Retrieved 12 6, 2012, from http://www.medicinenet.com: http://www.medicinenet.com/psychotic_disorders/article.htm

RCW 71.05.153.

Reading, M. (2012, 12). (D. Nelson, Interviewer)

San Fransisco Suicide Prevention. (n.d.). *San Fransisco Suicide Prevention*. Retrieved November 29, 2012, from www.sfsuicide.org: http://www.sfsuicide.org/prevention-strategies/statistics/

Watson, J. (2012, 12). (D. Nelson, Interviewer)

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